Center for Advanced Reproductive Services a first fertility center

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Request for Sperm Test

By appointment only (at-home testing may be available)
Please call 860-321-7082 or 860-525-8283 to discuss locations/options for testing

Patient Name: _____ DOB: _____

Patient Phone: _____ Referring Physician Name: _____

Physician Address: _____

Physician Phone: _____ Physician Fax: _____

Physician Email: _____

Please indicate the diagnosis and procedure requested:

Diagnosis:

____ Azoospermia N46.01

____ Varicocele I86.1

____ Oligospermia N46.11

____ Male Infertility - Unspecified Origin N46.9

____ Vasectomy Z98.52

____ Other: _____

_____

Test:

____ Comprehensive semen analysis (89320)

____ Cryopreservation of sperm (89259)

____ Cryopreservation of testicular tissue (89335)

____ Count and motility only (89310)

____ MESA (89257)

____ TESA (89264)

____ Other: _____

_____

*Insurance: _____ *Ins. ID Number: _____

*Is prior authorization required? ☐ Yes ☐ No *Ins. Auth Number (if applicable): _____

CARS Tax ID: 061522659 **NPI: 1891978219**

Physician's Signature: _____ Date: _____

Name of Referred's Spouse or Partner: _____

Additional Comments: _____

_____

***If insurance info/auth is incomplete, or if the physician's signature isn't included, the appointment may not be rendered and/or billed to insurance.**

All referrals are to be faxed to 860-838-6481